Release and/or Request of Medical Information

Client/Parent/Guardian name: ____________________ Date of birth: ______________

Child's name: _________________________________ Date of birth: _______________

Please only release or request relevant medical documentation from/to the following:

Child's Pediatrician & Practice Name: _______________________________________

Mother's Midwife or OB/GYN & Practice Name: ________________________________

Specialist Physician/Practice: ____

Specialist Physician/Practice: ____

Specialist Physician/Practice: ____

Other: ____

Other: ____

Is Milk & Honey authorized to leave detailed phone messages to any of the physicians listed above?

☐ Yes ☐ No

My signature authorizes Milk & Honey LLC to release and/or request medical and treatment information regarding me or my child from the providers and organization listed above.

Signature: ____ Date: ________________

Print name: _______________________________________

☐ By checking this box, I am acknowledging that I am electronically signing this form.